Commonwealth of Kentucky•Department of Insurance • 215 West Main Street • P.O. Box 517 • Frankfort, KY 40602
502-564-6082 • FAX 502-564-4604

APPLICATION FOR CERTIFICATE OF FILING AS A SELF-INSURED EMPLOYER-ORGANIZED ASSOCIATION

1. Name of Applicant:_____

2. Address of principal office:_____

   City:_____ State:_____ZIP: _____

   Contact Person: _____

   Phone: _____ Ext.: _____ FAX: _____

   Email Address:_____

3. Address to which official communications should be mailed (if different from above):

_____

_____

4. Address where books and records of the group will be maintained:

_____

_____

5. The applicant is a (check all that apply):

   ( ) Eligible association as defined in KRS 304.17A-005

   a) Date the entity began marketing a health insurance program to members:

   _____

   b) Is the entity insurer controlled? ( ) Yes ( ) No

c) Does membership consist principally of employers? ( ) Yes ( ) No

d) Are the entity's health insurance related issues decided by a board or committee of whom the majority is represented with employer members? ( ) Yes ( ) No

e) Are the entity's health insurance decisions recorded in written minutes or other written documentation? ( ) Yes ( ) No

( ) Entity organized under KRS 247.240 to 247.370

( ) Bona fide association as defined in 41 U.S.C. Section 300gg-91(d)(3)
*Please provide supporting documentation and copies of forms filed with the U.S. Dept. of Labor. Has the applicant received a letter of approval from the U.S. Dept. of Labor as an authorized self-insured group or association? ( ) Yes ( ) No

6. Date and place of organization: _____

_____

7. Date fiscal year ends: _____

8. Name and address of agent of service of process: _____

_____

_____

9. Is the group composed of governmental entities?
(check one) ( ) Yes ( ) No

10. If question 9 was answered "yes," describe the governmental entities involved (attach additional pages if necessary):

_____

_____

_____

11. Will the group have an administrator? (check one): ( ) Yes ( ) No

12. If question 11 was answered "yes," give the name and address of the administrator:

_____

_____

13. Will the group utilize a service company as defined in KRS 304.48-020(10)? (check one): ( ) Yes ( ) No

14. If question 13 was answered "yes," give the name and address of the service company:

_____

_____

_____

15. State whether any member of the board of directors/trustees has any direct or indirect interest in an administrator or service company and describe such interest. (Attach additional sheets if necessary):

_____

_____

_____

16. Attach the following information:

a. The names and addresses of group members. If not known, provide a description of the group to be solicited for membership.
b. A form describing the health coverage given to each member.
c. Documents relating to eligibility for health coverage.
d. A copy of the articles of association or other charter documents of the association and any by-laws of the group.
e. A copy of agreements with the administrator and with any service company.
f. Designation of the initial board of trustees/directors.
g. Biographical data (Form 501) for all members of the board of trustees/directors.
h. A statement describing the self-insured employer-organized association which shall include:
    (a) The health services to be offered;
    (b) The financial risks to be assumed;
    (c) The initial geographic area to be served;
    (d) Proforma financial projections for the first three (3) years of operation, including the assumptions the projections are based upon;
    (e) The sources of working capital and funding;
    (f) A description of the persons to be covered by the self-insured employer-organized association;
    (g) Any proposed reinsurance arrangements;
    (h) Any proposed management, administrative, or cost-sharing arrangements; and
    (i) A description of the self-insured employer-organized association's proposed method of marketing;
i. Certification of the group's financial solvency as set forth in KRS
j. The current number of members in the association.
k. The current number of members enrolled in any health plan offered through the association.
l. The current number of members in the association.
m. The current number of members enrolled in any health plan offered through the association.

17. In consideration of the approval of this application the applicant hereby expressly agrees, before approval or disapproval of this application, to:

    a. File with the Department of Insurance any other information requested by the Department.
    b. Immediately notify the Department in writing of any change in any information filed herein and immediately give the Department the correction.

18. Please provide an affidavit from each member of the board of directors attesting to the veracity of the information contained in the application.

_____

(Association's Name)

by signing this registration, agrees to comply with all applicable provisions of Kentucky law, including, but not limited to KRS 304.17A-320.

Officer's Signature: _____

Officer's Name: _____

Officer's Title: _____

Officer's Phone Number: _____

Officer's Fax Number: _____

Date: _____

Return completed original form and three (3) copies to the address provided above.